

Appendix 1
National HCFA 1500 Claim Form Sample

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																															
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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					12. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																																																																																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																																																																										
7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																																																																																																																																																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																																																																																																																										
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																										
13. INSURED'S POLICY OR GROUP NUMBER					14. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																										
15. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					16. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																										
17. EMPLOYER'S NAME OR SCHOOL NAME					18. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																										
19. INSURANCE PLAN NAME OR PROGRAM NAME					20. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																																																																																																																																																																																																										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																																																																																																																																																																																																															
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																																																																																															
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)																																																																																																																																																																																																															
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																																																																															
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE																																																																																																																																																																																																															
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																															
19. RESERVED FOR LOCAL USE																																																																																																																																																																																																															
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																																																																																																																																																																																																															
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																															
23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																															
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From</th> <th>To</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EMG		COB		RESERVED FOR LOCAL USE		From	To	MM	DD	YY	MM	DD	YY															1																						2																						3																						4																						5																						6																					
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25. FEDERAL TAX I.D. NUMBER SSN EIN																																																																																																																																																																																																															
26. PATIENT'S ACCOUNT NO.																																																																																																																																																																																																															
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																																															
28. TOTAL CHARGE \$																																																																																																																																																																																																															
29. AMOUNT PAID \$																																																																																																																																																																																																															
30. BALANCE DUE \$																																																																																																																																																																																																															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)																																																																																																																																																																																																															
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)																																																																																																																																																																																																															
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																																																																																																																																																																																																															
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